FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0009258

Facility Name: Good Samaritan Home

Address: 2130 Harrison Street (Number) Quincy (City) 62301 (Zip Code)

County: Adams

Telephone Number: (217) 223-8717 **Fax #** (217) 223-6015

IDPA ID Number: 370724112001

Date of Initial License for Current Owners: 2/22/1957

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ms. Judy M. Graham **Telephone Number:** (217) 223-8717
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/04 to 09/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Mr. Michael Duffy
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax #

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	132	48,180	3
4		Intermediate/DD			4
5	97	Sheltered Care (SC)	97	35,405	5
6		ICF/DD 16 or Less			6
7	275	TOTALS	275	100,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,639	2,613	2,801	7,053	8
9	SNF/PED					9
10	ICF	19,622	59,582		79,204	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,261	62,195	2,801	86,257	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.93%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy - Pool Exercise Classes

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/22/57

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 2,801

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/05 Fiscal Year: 09/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	850,709	53,523	14,984	919,216		919,216		919,216			1
2	Food Purchase		670,324		670,324		670,324	(14,526)	655,798			2
3	Housekeeping	236,720	42,034	27,910	306,664		306,664	(4,100)	302,564			3
4	Laundry	137,360		16,703	154,063		154,063		154,063			4
5	Heat and Other Utilities			373,380	373,380		373,380		373,380			5
6	Maintenance	232,378	46,627	142,035	421,040		421,040		421,040			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,457,167	812,508	575,012	2,844,687		2,844,687	(18,626)	2,826,061			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	4,291,977	221,280	29,082	4,542,339		4,542,339		4,542,339			10
10a	Therapy		2,389	562,236	564,625		564,625		564,625			10a
11	Activities	141,774	3,683	11,152	156,609		156,609		156,609			11
12	Social Services	126,606	2,402	705	129,713		129,713		129,713			12
13	CNA Training	23,272		3,328	26,600		26,600		26,600			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,583,629	229,754	610,103	5,423,486		5,423,486		5,423,486			16
	C. General Administration											
17	Administrative	179,682			179,682		179,682		179,682			17
18	Directors Fees											18
19	Professional Services			28,893	28,893		28,893	(251)	28,642			19
20	Dues, Fees, Subscriptions & Promotions			49,696	49,696		49,696	3,007	52,703			20
21	Clerical & General Office Expenses	405,856	69,745	143,355	618,956		618,956	(51,596)	567,360			21
22	Employee Benefits & Payroll Taxes			1,405,468	1,405,468		1,405,468		1,405,468			22
23	Inservice Training & Education			2,435	2,435		2,435		2,435			23
24	Travel and Seminar			14,341	14,341		14,341	(2,305)	12,036			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			175,912	175,912		175,912		175,912			26
27	Other (specify):*											27
28	**TOTAL General Administration**	585,538	69,745	1,820,100	2,475,383		2,475,383	(51,145)	2,424,238			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,626,334	1,112,007	3,005,215	10,743,556		10,743,556	(69,771)	10,673,785			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Good Samaritan Home #0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			482,726	482,726		482,726	(22,522)	460,204			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			482,726	482,726		482,726	(22,522)	460,204			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,003		57,003		57,003		57,003			39
40	Barber and Beauty Shops	53,886	3,727	724	58,337		58,337		58,337			40
41	Coffee and Gift Shops	21,353	28,697		50,050		50,050		50,050			41
42	Provider Participation Fee			100,505	100,505		100,505	(3,050)	97,455			42
43	Other (specify):* Nonallowable Costs	58,095		754,244	812,339		812,339	(812,339)				43
44	**TOTAL Special Cost Centers**	133,334	89,427	855,473	1,078,234		1,078,234	(815,389)	262,845			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,759,668	1,201,434	4,343,414	12,304,516		12,304,516	(907,682)	11,396,834			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,526)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,623)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,644)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,032)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5A	(859,857)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (907,682)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (907,682)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Good Samaritan Home
0009258
09/30/05

Schedule !

Schedule 5A

VI. ADJUSTMENT DETAIL
NON-ALLOWABLE EXPENSES
LINE 29 - Other

Description	Amount	Schedule V Reference
Out of period legal fees	(251)	19
Facility License Expense	3,750	21
To disallow Rotary Club and Chamber of Commerce Dues	(743)	20
To disallow non-allowable Hurricane Relief Contributions	(15,000)	21
To disallow non-allowable United Way Contribution	(400)	21
To disallow radio station expense	(756)	43
To disallow X-Ray expense	(1,574)	43
To disallow Lab expense	(5,799)	43
To disallow investment consultants	(244,166)	43
To disallow out of period seminar cost	(3,418)	24
To record last year out of period cost for seminars that related to this ye	1,113	24
To offset guest room income	(2,899)	30
To disallow cottage service income	(4,100)	3
To offset miscellaneous income	(552)	21
To offset discount earned income	(520)	21
To disallow Property Taxes	(28,138)	43
To disallow rental property expenses	(8,708)	43
To disallow radio station depreciation	(26)	43
To disallow cottage expenses	(509,496)	43
To disallow CMS - PICMP Payment	(3,050)	42
To disallow Public Relation Wages	(35,124)	21
Total	**(859,857)**	

5A

STATE OF ILLINOIS **Page 5A**

Good Samaritan Home

ID# **0009258**

Report Period Beginning: **10/01/04**

Ending: **09/30/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. - Part A	$		1
2	Labs - Part A			2
3	X-Rays - Part A			3
4	Vending Machine Expense			4
5	Disallowed Non-Care Related Real Estate Tax			5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Good Samaritan Home **#** 0009258 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,526)	0	0	0	0	0	0	0	0	0	0	(14,526)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,526)	0	0	0	0	0	0	0	0	0	0	(14,526)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,526)	0	0	0	0	0	0	0	0	0	0	(14,526)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(19,623)	0	0	0	0	0	0	0	0	0	0	(19,623)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,623)	0	0	0	0	0	0	0	0	0	0	(19,623)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,676)	0	0	0	0	0	0	0	0	0	0	(13,676)	43
44	**TOTAL Special Cost Centers**	(13,676)	0	0	0	0	0	0	0	0	0	0	(13,676)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(47,825)	0	0	0	0	0	0	0	0	0	0	(47,825)	45

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4		N/A								4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3	N/A											3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ None** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Good Samaritan Home **#** 0009258 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2004	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1200.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Good Samaritan Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0009258

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE _____ FAX #: _____

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.	N/A		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 169,463 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Residential Cottage Apartments 160 units for 174,278 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred:

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	1,219,680	1956-1999	$ 128,278	1
2					2
3	TOTALS			$ 128,278	3

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30			1957	$ 358,309	$	40	$	$	$ 358,309	4
5	75			1962	683,823		40			683,823	5
6	99			1973	1,683,761	42,094	40	42,094		1,342,111	6
7	75			1984	1,953,541	48,839	40	48,839		1,054,102	7
8											8
	Improvement Type**										
9	Building Service Equipment			1973							9
10	Land Improvements			1974							10
11	Building Improvements			1974	89,670		30			89,670	11
12	Building Improvements			1975							12
13	Building Improvements			1976	9,414		20			9,414	13
14	Building Improvements			1977	3,107		20			3,107	14
15	Building Service Equipment			1978	5,714		15			5,714	15
16	Building Improvements			1979							16
17	Building Service Equipment			1979	9,188		Various			9,188	17
18	Building Service Equipment			1980	324		Various			324	18
19	Building Improvements			1982	151,081	4,555	Various	4,555		121,844	19
20	Building Service Equipment			1982	17,350		Various			17,350	20
21	Building Service Equipment			1983	10,058		20			10,058	21
22	Land Improvements			1984	49,187		15			49,187	22
23	Building Service Equipment			1984	459,501	425	Various	425		455,924	23
24	Land Improvements			1985	2,601	4,254	20	1,355	(2,899)	2,601	24
25	Building Improvements			1985	250,935	6,273	40	6,273		127,143	25
26	Building Service Equipment			1985	179,735	4,999	Various	4,999		179,735	26
27	Land Improvements			1986	72,453	3,430	20	3,430		70,455	27
28	Building Improvements			1986	161,531	4,038	40	4,038		77,636	28
29	Building Service Equipment			1986	137,391	6,241	Various	6,241		120,296	29
30	Building Improvements			1987	19,089	500	Various	500		8,966	30
31	Building Service Equipment			1987	21,221	1,061	20	1,061		19,448	31
32	Land Improvements			1988		891	20	891			32
33	Building Service Equipment			1988	14,400	42	Various	42		14,075	33
34	Building Improvements			1989	174,123	4,421	Various	4,421		117,189	34
35	Building Service Equipment			1989	6,469		Various			6,469	35
36	Garage Additions			1990	78,563	2,619	30	2,619		41,027	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Roof - North Wing	1990	$ 43,980	$ 2,199	20	$ 2,199	$	$ 33,901	37
38	Phones	1990	600		10			600	38
39	Hall Renovations	1991	20,616	1,031	20	1,031		15,033	39
40	Building Improvements State Audit Adjustments 10881+30372	1991	511,992	18,441	30	17,066	(1,375)	244,560	40
41	Ceiling/partitions	1991	37,276	1,243	30	1,243		17,810	41
42	Office Entrance	1991	14,768	738	20	738		11,076	42
43	Building Services Equipment State Aduit Adjustment of 359	1991	83,893	1,465	various	1,441	(24)	83,675	43
44	Parking Lot	1992	4,257	213	20	213		2,554	44
45	Building Services Equipment	1992	2,706		10			2,706	45
46	Parking Lot	1992	46,071	2,303	20	2,303		28,987	46
47	Kitchen/Dining Room	1993	310,412	7,760	40	7,760		95,711	47
48	Building Services Equipment	1993	20,910	238	various	238		17,841	48
49	Parking Lot	1994	87,827	5,855	15	5,855		68,798	49
50	Manhole/Sewer	1994	2,859	191	15	191		2,224	50
51	Sidewalk	1994	7,875	525	15	525		5,819	51
52	West Nursing	1994	66,876	3,344	20	3,344		36,782	52
53	Dining Room	1994	6,990	315	various	315		4,468	53
54	Building Services Equipment	1994	134,323	2,791	various	2,791		111,301	54
55	West Nursing	1995	128,327	6,416	20	6,416		67,906	55
56	West Nursing	1995	3,151	158	20	158		1,497	56
57	Building Services Equipment	1995	22,482	1,141	various	1,141		18,895	57
58	Gas Line	1996	3,062	153	20	153		1,454	58
59	Gutters	1996	10,817	541	20	541		5,138	59
60	Eber Wing Improvements	1996	20,335	1,017	20	1,017		9,659	60
61	Roof	1996	9,016	451	20	451		4,283	61
62	Roof - Anna Brown Wing	1996	70,800	3,540	20	3,540		31,565	62
63	Building Services Equipment	1996	46,663	2,950	various	2,950		28,028	63
64	Lights/Front Land Improvements	1997	5,360	357	15	357		3,127	64
65	Walls/Floor - Anna Brown Wing	1997	41,780	2,089	20	2,089		17,757	65
66	Freezer Floor	1997	4,394	258	17	258		2,326	66
67	Roof-Anna Brown Wing	1997	48,740	1,250	39	1,250		9,815	67
68	Sprinkling System	1997	3,354	335	10	335		2,515	68
69	Tamper Detectors	1997	2,818	282	10	282		2,114	69
70	TOTAL (lines 4 thru 69)		$ 8,427,869	$ 204,272		$ 199,974	$ (4,298)	$ 5,985,090	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,427,869	$ 204,272		$ 199,974	$ (4,298)	$ 5,985,090	1
2	Compressor - Eber	1997	2,039	136	15	136		1,133	2
3	Compressor - East	1997	11,808	787	15	787		6,494	3
4	Sprinkler System	1997	102,875	5,144	20	5,144		41,579	4
5	Air Exchange -Pool Area State Audit adjustment 480	1997	8,092	571	15	539	(32)	4,447	5
6	Roof- Kitchen/Dinning	1998	45,550	1,168	39	1,168		9,048	6
7	Elevator Doors Dietary	1998	1,095	110	10	110		822	7
8	Underground Tanks - Disposal 2005	1998		8,082	10	1,155	(6,927)		8
9	Remodeling -Anna Brow Wing Walls, Celing, Floors,Lights	1999	199,131	4,978	39	4,978		30,906	9
10	Remodeling -Anna Brow Wing - Duct Detectors	1999	1,444		5			1,444	10
11	Remodeling -Anna Brow Wing - Carpeting	1999	2,966	297	10	297		1,928	11
12	Remodeling -Anna Brow Wing - Fire Damper	1999	21,915	548	39	548		3,493	12
13	Chapel Roof	1999	21,515	538	39	538		3,698	13
14	Fire Damper Alarm	1999	5,490		5			5,490	14
15	Eber Parking Lot Lights	1999	5,495	366	15	366		2,381	15
16	Lawn - Disposals of in 2005	1999							16
17	Stainless Steel D/W Exhaust	1999	1,659	166	10	166		1,078	17
18	Wiring Chapel Roof	1999	332	33	10	33		216	18
19	HVAC Chapel	1999	23,760	1,584	15	1,584		10,296	19
20	Code Alert System	1999	61,985		5			61,985	20
21	Elevator Upgrade A/B East	1999	22,556	2,256	10	2,256		14,661	21
22	Elevator Upgrade - Special Care	1999	5,970	597	10	597		3,881	22
23	Fire Protection A/B	1999	4,500	450	10	450		2,925	23
24	Condensor Unit	1999	22,945	1,530	15	1,530		9,943	24
25	Fire Proctection Pool Area	1999	776	78	10	78		504	25
26	Damper Duct Work	1999	5,602	373	15	373		2,427	26
27	Lighting- Special Care	1999	2,075	138	15	138		899	27
28	Chapel Remodeling - Fire Damper	2000	3,196	213	15	213		1,172	28
29	Chapel Remodeling - Sign	2000	77	7	5	7		77	29
30	Chapel Remodeling - Painting	2000	4,751	119	39	119		599	30
31	Chapel Remodeling - Carpeting	2000	3,073	205	15	205		1,127	31
32	Chapel Remodeling - Unity & Pews	2000	14,760	369	39	369		1,860	32
33	Kitchen Remodeling - Hood Move to Equip per State Audi	2000							33
34	TOTAL (lines 1 thru 33)		$ 9,035,301	$ 235,115		$ 223,858	$ (11,257)	$ 6,211,603	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,035,301	$ 235,115		$ 223,858	$ (11,257)	$ 6,211,603	1
2	Kitchen Remodeling - Sky Roof Flashing	2000	3,086	206	15	206		1,132	2
3	Kitchen Remodeling - Sidewalls	2000	3,485	232	15	232		1,277	3
4	Kitchen Remodeling - Galvanized Wall Divider	2000	2,601	173	15	173		953	4
5	East Nursing Remodeling - Walls, Ceilings, Floors	2000	26,757	669	39	669		3,540	5
6	Eber Wing Smoke Damper	2000	16,485	1,099	15	1,099		6,045	6
7	Special Care Lighting	2000	14,290	953	15	953		5,240	7
8	HVAC Rehab Eber Wing	2000	305,419	20,361	15	20,361		111,987	8
9	Groundkeeper move to Equipment per state audi	2000							9
10	3 Ton Rooftop Unit A/C West Dining	2000	2,776	185	15	185		1,018	10
11	Telephone Unit	2000	323	46	7	46		254	11
12	Elevator Up Grade East Wing	2000	12,776	852	15	852		4,685	12
13	Superior Boiler Burner Up Grade	2000	1,101	73	15	73		403	13
14	Entrance Codelock Special Care	2000	1,848	123	15	123		677	14
15	Life Safety Code Sprinkler Drains	2000	7,000	467	15	467		2,567	15
16	Land Improvement New Sidewalk	2000	1,200	60	20	60		270	16
17	Renovation of East nursing Wing	2001	369,213	9,230	39	9,230		38,844	17
18	Exterior Painting	2001	14,347	956	15	956		4,304	18
19	Painting Kitchen	2001	2,550	170	15	170		765	19
20	Chapel Renovation	2000	2,001	50	39	50		244	20
21	Kitchen Electrical Work	2000	611	41	15	41		183	21
22	HVAC Rehab Eber Wing	2000	5,584	372	15	372		1,675	22
23	Sprinklers	2000	4,151	277	15	277		1,245	23
24	Wet Chemical Fire Suppressor Work	2000	3,695	246	15	246		1,108	24
25	Electrical Work	2001	1,609	107	15	107		482	25
26	Smoke/ Fire Damper East, South and Ebe	2001	50,735	3,382	15	3,382		15,221	26
27	Air Compressor Anna Brown Wing	2001	10,911	728	15	728		3,273	27
28	3D Detectors in Elevators	2001	4,916	376	10	376		1,531	28
29	Exhaust fan move to Equipment per state audi	2001							29
30	Compensators	2001	2,724	208	10	208		848	30
31	33 Lever Passage Locks	2002	2,904	222	10	222		905	31
32	Exit Lights and Hold Opens	2002	966	74	10	74		301	32
33	16 Lever Passage Locks	2002	1,408	108	10	108		439	33
34	TOTAL (lines 1 thru 33)		$ 9,912,773	$ 277,161		$ 265,904	$ (11,257)	$ 6,423,019	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,912,773	$ 277,161		$ 265,904	$ (11,257)	$ 6,423,019	1
2	48 Lockouts	2002	985	75	10	75		307	2
3	Water Piping	2001	4,600	115	39	115		446	3
4	New Curb & Driveway	2002	16,118	708	20	708		2,662	4
5	Buffet in Dining Area	2003	2,977	198	15	198		532	5
6	Door - code alert and keypad	2003	2,489	249	10	249		664	6
7	Fire Collars	2003	3,619	362	10	362		948	7
8	Kitchen Exhaust Fans move to Equipment per state audit	2003							8
9	Main Breaker	2003	3,291	219	15	219		457	9
10	Elevator Master Door Operator	2003	4,278	428	10	428		1,034	10
11	Training Room Drainage	2003	731	19	39	19		47	11
12	Dietary - Floor Drain	2003	223	6	39	6		14	12
13	Handicap Accessible Entrance and Sidewalk	2003	3,200	160	20	160		320	13
14	Annunciators	2004	51,494	5,149	10	5,149		7,724	14
15	Sewer Lines	2003	5,801	387	15	387		741	15
16	Smoke Damper - Eber	2003	698	46	15	46		85	16
17	Beauty Shop Wiring	2003	2,272	151	15	151		265	17
18	Dietary Doors	2004	3,801	253	15	253		422	18
19	Roof	2004	4,028	268	15	268		402	19
20	Remote Annunciator	2004	4,650	465	10	465		620	20
21	Cooler Expansion	2004	6,120	408	15	408		544	21
22	Parking Lot	2004	6,800	453	15	453		566	22
23	Ambulance Garage Doors	2004	1,070	107	10	107		125	23
24	Kitchen Remodel	2004	6,425	643	10	643		643	24
25	Motor for Laundry Washer move to Equip per state audit	2004							25
26	Plumbing wok in Eber/South	2004	5,147	286	15	286		286	26
27	Water Softener System	2004	15,642	1,173	10	1,173		1,173	27
28	Storage Tank Replacement	2004	2,454	184	10	184		184	28
29	Air Handler in East Circle	2005	1,297	54	10	54		54	29
30	Parking Lot Off-Street	2005	68,884	1,531	15	1,531		1,531	30
31	Kitchen Electrical Work	2004	247	12	20	12		12	31
32	Kitchen Remodel	2004	1,248	57	20	57		57	32
33	Sprinkler System	2004	980	41	20	41		41	33
34	TOTAL (lines 1 thru 33)		$ 10,144,342	$ 291,368		$ 280,111	$ (11,257)	$ 6,445,925	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,144,342	$ 291,368		$ 280,111	$ (11,257)	$ 6,445,925	1
2	Exhaust Fan for Dishwasher move to equip per state audit	2004							2
3	Sprinkler System	2005	2,373	79	20	79		79	3
4	Tunnel Closure	2005	1,888	84	15	84		84	4
5	Perry Suite Renovations	2005	2,470	96	15	96		96	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Guest Room Income Offset					(2,899)	(2,899)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,151,073	$ 291,627		$ 277,471	$ (14,156)	$ 6,446,184	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,258,845	$ 150,667	$ 148,307	$ (2,360)	3-20 yrs	$ 585,182	71
72	Current Year Purchases	135,954	9,734	9,734		5-10 yrs	9,734	72
73	Fully Depreciated Assets	780,115				3-20 yrs	780,115	73
74								74
75	TOTALS	$ 2,174,914	$ 160,401	$ 158,041	$ (2,360)		$ 1,375,031	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident	Various	Various	$ 74,241	$ 7,456	$ 1,450	$ (6,006)	3-5 yrs	$ 74,241	76
77	Maintenance	Various	Various	43,395				5 yrs	43,395	77
78	Maintenance	Various	Various	1,219				3 yrs	1,219	78
79	See Attach Sch 13A	Various	Various	147,227	23,242	23,242		5 yrs	33,977	79
80	TOTALS			$ 266,082	$ 30,698	$ 24,692	$ (6,006)		$ 152,832	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,720,347	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 482,726	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 460,204	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (22,522)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,974,047	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage Land	$ 76,532	$	$	86
87	Rental Property Land	75,730			87
88	Cottage Fixed Assets	8,192,046	230,974	4,761,394	88
89	Rental Property Fixed Assets	233,780	8,708	55,582	89
90	Radio Station	14,161	26	14,090	90
91	TOTALS	$ 8,592,249	$ 239,708	$ 4,831,066	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$	$	$	$ 0		$	37
38	Current Year Purchases				0			38
39	Fully Depreciated Assets				0			39
40					0			40
41	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	Toro 2001	2001	$ 825	$ 116	$ 116	$ 0	5 yrs	$ 479	42
43	Maintenance	Chevy S-10 98	2002	7,508	1,051	1,051	0	5 yrs	4,354	43
44	Facility	Toro mower	2003	7,139	1,428	1,428	0	5 yrs	3,570	44
44a	Facility	Ford/Goshen Bus (2)	2004	98,532	19,706	19,706	0	5 yrs	24,633	44a
44b	Facility	Lift for Van	2005	1,500	125	125	0	5 yrs	125	44b
44c	Facility	Toto mower	2005	9,792	816	816	0	5 yrs	816	44c
45	Facility	2005 Chrysler Town	2005	21,931	0	0	0	5 yrs	0	45
46	TOTALS			$ 147,227	$ 23,242	$ 23,242	$ 0		$ 33,977	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☒ X NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$ N/A
13.	/2007	$ N/A
14.	/2008	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18		N/A			18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,362	$	$ 1,362
2	Books and Supplies	60	1,356		1,416
3	Classroom Wages (a)		7,797		7,797
4	Clinical Wages (b)		3,840		3,840
5	In-House Trainer Wages (c)		11,635		11,635
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		550		550
9	TOTALS	$ 60	$ 26,540	$	$ 26,600
10	SUM OF line 9, col. 1 and 2 (e)	$ 26,600			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$ 2,592

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	3
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	1
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a C 3	hrs	$	2,110	$ 189,925	$	2,110	$ 189,925	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		569	51,196		569	51,196	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 2,3	hrs		3,567	321,115	2,389	3,567	323,504	4
5	Physician Care		visits							5
6	Dental Care	L.10 C 2, 3	visits		12	2,400	350	12	2,750	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39 C 2	# of prescrpts				57,003		57,003	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	6,258	$ 564,636	$ 59,742	6,258	$ 624,378	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Good Samaritan Home
Provider #: 0009258
10/01/04 to 09/30/05 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 09/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 426,048	$ 426,048	1
2	Cash-Patient Deposits	23,048	23,048	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	1,469,434	1,469,434	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,166,117	1,166,117	5
6	Prepaid Insurance	72,896	72,896	6
7	Other Prepaid Expenses	1,342	1,342	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Application Fee Repurchase	28,637	28,637	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,187,522	$ 3,187,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	28,361,384	28,361,384	12
13	Land	128,278	128,278	13
14	Buildings, at Historical Cost	10,449,614	10,151,073	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,434,297	2,440,996	16
17	Accumulated Depreciation (book methods)	(8,244,858)	(7,974,047)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Cottage & Rental Property	3,761,184	3,761,184	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 36,889,899	$ 36,868,868	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 40,077,421	$ 40,056,390	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 258,214	$ 258,214	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,048	23,048	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	401,565	401,565	30
31	Accrued Taxes Payable (excluding real estate taxes)	57,885	57,885	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,282		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Sch 17C	137,574	137,574	36
37	Prepaid Residents Rent	744,189	744,189	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,647,757	$ 1,622,475	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,647,757	$ 1,622,475	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 38,429,664	$ 38,433,915	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 40,077,421	$ 40,056,390	48

***(See instructions.)**

Good Samaritan Home
0009258
09/30/05

Schedule 17C

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Miscellaneous Employee Deductions	(1,533)	(1,533)
Employee Assist Fund Withheld	5,503	5,503
Benevolent Fund Payable	3,085	3,085
Application Fee Payable	28,230	28,230
Medicare Liability	13,017	13,017
Medicaid Liability	23	23
Employee Health/Life Liability	86,183	86,183
Total Line 36 - Other Current Liabilities(specify):	**134,508**	**134,508**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 35,761,784	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 35,761,784	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,676,670	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,676,670	17
	B. Transfers (Itemize):		
18	**Round**	4	18
19	**Chapel Transfer Account**	(8,794)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (8,790)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 38,429,664	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,843,655	1
2	Discounts and Allowances for all Levels	(1,103,828)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,739,827	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	927,664	6
7	Oxygen	3,143	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 930,807	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	32,836	12
13	Barber and Beauty Care	60,571	13
14	Non-Patient Meals	14,526	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	102,517	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,004	19
20	Radiology and X-Ray	3,065	20
21	Other Medical Services	68,321	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 291,840	23
	D. Non-Operating Revenue		
24	Contributions	40,944	24
25	Interest and Other Investment Income***	3,673,318	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,714,262	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attach Schedule 19E	41,536	28
28a	Cottage and Rental Property Income	1,262,914	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,304,450	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,981,186	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,844,687	31
32	Health Care	5,423,486	32
33	General Administration	2,475,383	33
	B. Capital Expense		
34	Ownership	482,726	34
	C. Ancillary Expense		
35	Special Cost Centers	977,729	35
36	Provider Participation Fee	100,505	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,304,516	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,676,670	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,676,670	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Good Samaritan Home
0009258
09/30/05

Schedule 19E

XVII. INCOME STATEMENT

Revenue

E. Other Revenue (specify):	Amount
Miscellaneous Income	552
Discount Earned Income	520
Guest Room Income	2,899
Van Transportation	29,665
Cottage Services Income	4,100
Application Fee Income	3,800
Total Line 28 - Other Revenue (specify):	**41,536**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,946	2,111	$ 66,907	$ 31.69	1
2	Assistant Director of Nursing	2,045	2,103	48,838	23.22	2
3	Registered Nurses	19,047	21,182	381,514	18.01	3
4	Licensed Practical Nurses	70,990	78,503	1,218,944	15.53	4
5	CNAs & Orderlies	196,634	215,457	2,244,915	10.42	5
6	CNA Trainees	1,694	1,694	11,637	6.87	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,943	14,403	162,656	11.29	8
9	Activity Director	1,992	2,088	24,976	11.96	9
10	Activity Assistants	12,313	13,705	116,798	8.52	10
11	Social Service Workers	12,300	13,715	126,606	9.23	11
12	Dietician					12
13	Food Service Supervisor	6,273	7,096	104,544	14.73	13
14	Head Cook	5,576	6,550	78,166	11.93	14
15	Cook Helpers/Assistants	60,833	67,014	582,099	8.69	15
16	Dishwashers	8,904	9,772	85,900	8.79	16
17	Maintenance Workers	20,991	23,255	232,378	9.99	17
18	Housekeepers	24,236	26,849	236,720	8.82	18
19	Laundry	13,030	14,527	137,360	9.46	19
20	Administrator	1,908	2,164	101,230	46.78	20
21	Assistant Administrator	1,924	2,080	78,452	37.72	21
22	Other Administrative	7,599	8,180	147,915	18.08	22
23	Office Manager					23
24	Clerical	18,572	21,525	257,941	11.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,988	2,200	31,481	14.31	31
32	Other Health Ca Sch 20A	12,118	13,511	148,357	10.98	32
33	Other(specify) Sch 20A	12,532	13,918	133,334	9.58	33
34	TOTAL (lines 1 - 33)	528,388	583,602	$ 6,759,668 *	$ 11.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	343	$ 11,671	L 1 C3	35
36	Medical Director	Monthly	3,600	L 9 C3	36
37	Medical Records Consultant	Monthly	1,950	L 10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,044	L 10 C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	641	L 11 C3	44
45	Social Service Consultant	10	705	L 12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	361	$ 28,611		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Good Samaritan Home
0009258
09/30/05

Schedule 20A

XVIII. STAFFING AND SALARY COSTS
LINE 32 - Other (Health Care specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Nurse Aide Instructor	612	612	$ 11,635	19.01
Nursing Secretary	7,359	8,136	74,877	9.20
Medical Supply Clerk	2,010	2,296	22,462	9.78
Staff Coord.	2,137	2,467	39,383	15.96
Total Line 32 - Other	**12,118**	**13,511**	**$ 148,357**	**$ 10.98**

XVIII. STAFFING AND SALARY COSTS
LINE 33 - Other (specify)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Maintenance Cottages	5,248	5,814	$ 58,095	9.99
Beauty Shop	4,850	5,427	53,886	9.93
General Store	2,434	2,677	21,353	7.98
Total Line 33 - Other	**12,532**	**13,918**	**$ 133,334**	**$ 9.58**

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michael Duffy	Administrator	0	$ 101,230
Judy Graham	Asst Admin.	0	78,452
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 179,682

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Schiff Hardin LLP	Legal	$ 7,744
Schmiedeskamp, Robertson	Legal	2,630
Neu & Mitchell		
Wade Stables PC	Accounting	17,300
ACH	Payroll Processing	636
Architechnics, Inc	Safety Code Issue	583
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,893

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 293,669
Unemployment Compensation Insurance	6,365
FICA Taxes	498,957
Employee Health Insurance	386,872
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Tuition	0
Pension Plan	176,014
Employee Medical	23,728
Life Insurance	4,090
Employee Recognition	15,773
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,405,468

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,750
Advertising: Employee Recruitment	21,898
Health Care Worker Background Check	
(Indicate # of checks performed 119)	2,159
Life Services Network	15,357
Council for Health and Human Services	7,381
Various Dues, Licenses, and Permits	2,158
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 52,703

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached Schedule	12,036
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,036

**See instructions.

Good Samaritan Home
Provider #: 0009258
10/01/04 to 09/30/05 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	28,893
Out of Period Cost for Legal	(251)
Total (agree to Schedule V, line 19, column 8)	28,642

Facility Name & ID Number Good Samaritan Home # 0009258 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Good Samaritan Home # 0009258 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $15,357 CHHS $7,381**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.88 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **82,440** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **97,455**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **14,526**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wade Stables P. C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is not complete will mail when done**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	850,709	53,523	14,984	919,216	0	919,216	0	919,216
2. Food Purchase	0	670,324	0	670,324	0	670,324	(14,526)	655,798
3. Housekeeping	236,720	42,034	27,910	306,664	0	306,664	(4,100)	302,564
4. Laundry	137,360	0	16,703	154,063	0	154,063	0	154,063
5. Heat and Other Utilities	0	0	373,380	373,380	0	373,380	0	373,380
6. Maintenance	232,378	46,627	142,035	421,040	0	421,040	0	421,040
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,457,167	812,508	575,012	2,844,687	0	2,844,687	(18,626)	2,826,061
9. Medical Director	0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records	4,291,977	221,280	29,082	4,542,339	0	4,542,339	0	4,542,339
10a. Therapy	0	2,389	562,236	564,625	0	564,625	0	564,625
11. Activities	141,774	3,683	11,152	156,609	0	156,609	0	156,609
12. Social Services	126,606	2,402	705	129,713	0	129,713	0	129,713
13. Nurse Aide Training	23,272	0	3,328	26,600	0	26,600	0	26,600
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	4,583,629	229,754	610,103	5,423,486	0	5,423,486	0	5,423,486
17. Administrative	179,682	0	0	179,682	0	179,682	0	179,682
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	28,893	28,893	0	28,893	(251)	28,642
20. Fees, Subscriptions & Promotion	0	0	49,696	49,696	0	49,696	3,007	52,703
21. Clerical & General Office	405,856	69,745	143,355	618,956	0	618,956	(51,596)	567,360
22. Employee Benefits & Payroll	0	0	1,405,468	1,405,468	0	1,405,468	0	1,405,468
23. Inservice Training & Education	0	0	2,435	2,435	0	2,435	0	2,435
24. Travel and Seminar	0	0	14,341	14,341	0	14,341	(2,305)	12,036
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	175,912	175,912	0	175,912	0	175,912
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	585,538	69,745	1,820,100	2,475,383	0	2,475,383	(51,145)	2,424,238
29. Total General Administrative	6,626,334	1,112,007	3,005,215	10,743,556	0	10,743,556	(69,771)	10,673,785
30. Depreciation	0	0	482,726	482,726	0	482,726	(22,522)	460,204
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	482,726	482,726	0	482,726	(22,522)	460,204
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	57,003	0	57,003	0	57,003	0	57,003
40. Barber and Beauty Shop	53,886	3,727	724	58,337	0	58,337	0	58,337
41. Coffee and Gift Shops	21,353	28,697	0	50,050	0	50,050	0	50,050
42	0	0	100,505	100,505	0	100,505	(3,050)	97,455
43. Other (specify):*	58,095	0	754,244	812,339	0	812,339	(812,339)	0
44. Total Special Cost Ce	133,334	89,427	855,473	1,078,234	0	1,078,234	(815,389)	262,845
45. Grand Total	6,759,668	1,201,434	4,343,414	12,304,516	0	12,304,516	(907,682)	11,396,834

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	426,048	426,048
2. Cash - Patient Deposits	23,048	23,048
3. Accounts & Notes Recievable	1,469,434	1,469,434
4. Supply Inventory	0	0
5. Short-Term Investments	1,166,117	1,166,117
6. Prepaid Insurance	72,896	72,896
7. Other Prepaid Expenses	1,342	1,342
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	28,637	28,637
10. Total current assets	3,187,522	3,187,522
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	########	28,361,384
13. Land	128,278	128,278
14. Buildings, at Historical Cost	########	10,151,073
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,434,297	2,440,996
17. Accumulated Depreciation (book methods)	-8,244,858	-7,974,047
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	3,761,184	3,761,184
24. Total Long-Term Assets	########	36,868,868
25. Total Assets	########	40,056,390
CURRENT LIABILITIES		
26. Accounts Payable	258,214	258,214
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	23,048	23,048
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	401,565	401,565
31. Accrued Taxes Payable	57,885	57,885
32. Accrued Real Estate Taxes	25,282	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	137,574	137,574
37. Other Current Liabilities (specify):	744,189	744,189
38. Total Current Liabilities	1,647,757	1,622,475
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	1,647,757	1,622,475
47.Total Equity	########	38,433,915
48.Total Liabilities and Equity	########	40,056,390

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	9,843,655
2. Discounts and Allowances for all Levels	-1,103,828
Subtotal - Inpatient Care	8,739,827
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	927,664
7. Oxygen	3,143
Subtotal - Anciliary Revenue	930,807
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	32,836
13. Barber and Beauty Care	60,571
14. Non-Patient Meals	14,526
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	102,517
18. Sale of Supplies to Non-Patients	0
19. Laboratory	10,004
20. Radiologyand X-Ray	3,065
21. Other Medical Services	68,321
22. Laundry	0
Subtotal - Other Operating Revenue	291,840
24. Contributions	40,944
25. Interest and Other Investments Income	3,673,318
Subtotal - Non-Operating Revenue	3,714,262
27. Other Revenue (specify):	41,536
28. Other Revenue (specify):	1,262,914
Subtotal - Other Revenue	1,304,450
30. Total Revenue	14,981,186
31. General Services	2,751,027
32. Health Care	4,819,805
33. General Administration	2,158,974
34. Ownership	438,167
35. Special Cost Centers	978,892
35. Provider Participation Fee	97,722
37. Other	0
40. Total Expenses	11,244,587
41. Income Before Income Taxes	3,736,599
42. Income Taxes	0
43. Net Income or Loss for the Year	3,736,599

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